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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>265844 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                | (X3) DATE SURVEY COMPLETED<br><br>08/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Aurora Health and Rehabilitation |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1200 McCutchen Road<br>Rolla, MO 65401 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45564</b></p> <p>Based on interview and record review, facility staff failed to protect one resident (Resident #1) from neglect when staff failed to properly secure a resident while they transported the resident in the facility vehicle. Facility staff failed to secure the shoulder strap across the resident and when the vehicle came to an abrupt stop, the resident fell over his/her lap belt and from his/her wheelchair which resulted in fractures of both femurs, thoracic spine fractures, and an upper arm fracture. The facility census was 78.</p> <p>The administrator was notified on 8/13/24 of past non-compliance, which occurred on 8/07/24. Staff assessed the resident, notified the resident's physician, sent the resident to the hospital, and in-serviced all transportation staff on the proper way to secure a resident in the van during transport. The IJ was corrected on 8/8/2024.</p> <p>Review of the Facility's Transportation Driving Safety Policy, reviewed 05/04/23, showed:</p> <ul style="list-style-type: none"> <li>-Drivers of company vans, buses or vehicles carrying residents should have at least three years of driving experience and will be required to complete initial and annual training per manufactures guidelines to include how to properly restrain a wheelchair and use of safety mechanisms for residents in wheelchairs per manufactures guidelines. The driver shall ensure each passenger is properly restrained to include wheelchair(s) properly fastened and shoulder strap in place and/or passenger seat belts are properly latched.</li> </ul> <p>Review of the facility's Q-Straint Series Securement-Device User Instructions Manual, undated, showed staff are directed as follows:</p> <ul style="list-style-type: none"> <li>-Place wheelchair face forward in securement area; apply wheel locks or turn power off;</li> <li>-Attach lap belts-use integrated stiffeners to feed belt through openings between seat backs and bottoms and/or armrests to ensure proper belt fit around occupant;</li> <li>-Attach shoulder belt-extend shoulder belt over passenger's shoulder and across upper torso and fasten pin connector onto lap belt;</li> <li>-Ensure belts are adjusted as firmly as possible, but consistent with user comfort.</li> </ul> <p>(continued on next page)</p> |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>1. Review of Resident #1's quarterly Minimum Data Set (MDS), dated [DATE], showed staff assessed the resident as follows:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Impairments to both sides of lower extremities;</li> <li>-Dependent to roll left and right;</li> <li>-Dependent to move from lying to sitting on bedside;</li> <li>-Used wheelchair.</li> </ul> <p>Review of the facility's investigation summary, dated 08/07/24, showed staff documented at approximately 10:33 A.M., the facility's van driver reported to the administrator he/she called 911 after having an accident with the resident while returning from the dialysis clinic. The driver told the administrator the car in front of him/her slammed on the brakes and he/she hit the brakes to avoid hitting the other car. The driver told the administrator the resident fell out of his/her wheelchair and may have bit his/her lip as there was some blood on the resident's mouth. Review showed the driver told the administrator Emergency Medical Services (EMS) arrived and encouraged the resident to be transported to the hospital.</p> <p>Review of Driver A's Incident Statement, dated 08/07/24, showed Driver A documented a vehicle abruptly applied its brakes in front of the transport van at an intersection, he/she applied the brakes so he/she would not hit the vehicle. He/She documented the resident gasped behind him/her. When he/she looked in the rearview mirror he/she saw the resident's mouth agape before the resident fell over his/her seatbelt. He/She pulled the van over to assess the resident. He/She documented the resident was silent and non-responsive so he/she called EMS, at which time the resident began to moan softly before responding to questions. Driver A documented the resident initially refused to go to the hospital, but after talking with EMS the resident agreed to go to the hospital for further assessment.</p> <p>Review of the hospital emergency department records, dated 08/07/2024 at 10:58 A.M., showed the patient was being transported from dialysis and was sitting in his/her wheelchair which was secured, however the patient was not strapped into the wheelchair. The transport vehicle slammed on the brakes causing the patient to fall forward onto his/her forehead. The patient reports that he/she is having pain between his/her shoulder blades, left shoulder, and in his/her right hip. He/She denies that he/she lost consciousness. He/She denies feeling dizzy and denies any nausea, vomiting, or headache. He/She states it hurts in his/her back whenever he/she takes a deep breath or moves any type of way. Review showed the patient had multiple fractures including T spine compression fractures (happens when one or more bones in the spine weaken and crumble), bilateral femur fractures (a broken bone in the long bone of the leg), and humerus fracture (a broken bone in the upper arm).</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>During an interview on 08/12/2024 at 9:28 A.M., Driver A said he/she went to the dialysis clinic to pick up the resident. Driver A said he/she fastened the chair restraints and fastened the waist buckle. He/She said a shoulder strap was not fastened because the resident did not like it on. Driver A said he/she approached an intersection and the car in front of them hit the brakes. Driver said he/she was going 20 miles per hour and hit the brakes to keep from hitting the vehicle in front them. Driver A said the resident went over the waist belt to the floorboard. Driver A said he/she pulled the van over and called EMS and the facility. Driver A said a police officer did stop, but did not speak with him/her. Driver A said when he/she was trained he/she did not use the manufacturer's Device User Instructions Manual. Driver A said a former employee provided a demonstration in the van, but did not tell him/her about using the shoulder strap.</p> <p>During an interview on 08/12/24 at 8:10 P.M., the administrator said facility staff had a driver's license review, van training, and a van loading competency before transporting residents. The administrator said he/she could not locate the original training documentation for Driver A. The administrator said staff were not monitoring to ensure the transport drivers were securing residents properly in the van prior to transport.</p> <p>MO00240339</p> |